A member's temporary absence from the approved placement (e.g. for hospitalization) will not impact the continuation of the approval upon the member's return. However, a previously approved reinsurance case where the member has been terminated for the circumstances described below can not be reapproved at a later date.

- Contractor's activity to transfer the member to a lower level of care.

- AHCCCS determines through the review process at renewal that the member no longer meets the criteria.

In addition to all other ALTCS case management standards, the following standards also apply to members covered under the ALTCS reinsurance program for high cost behavioral health:

1. A request for renewal of a reinsurance authorization must be submitted to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit using the form found in Exhibit 1620-6, within 10 business days prior to the expiration of the current approval. Additional provider documentation that supports the member's behaviors and need for intervention must also be submitted.

   AHCCCS will provide the Contractor with written verification of authorization or denial. Authorization will be granted for the member's current placement and setting only. If there is a subsequent change of placement or setting, information and documentation to describe the reason for the change must be submitted as a new reinsurance request.

2. The service plans for E/PD members who receive specialized services covered under the High Cost Behavioral Health Reinsurance program must be coordinated with the member's PCP and the Contractor's Medical Director.

3. Covered services may be provided in the member's own home, in a HCB approved alternative residential setting, an unclassified health care facility licensed by the Arizona Department of Health Services or a nursing facility if the provider offers specialized services necessary for individuals with significant behavior management problems. Services provided in inpatient settings, including residential treatment centers (RTC) are not covered under this reinsurance program.

4. All institutional and HCBS services described in Chapter 1200 of this Manual, including non-emergency transportation, are included in the High Cost Behavioral Health Reinsurance program. Behavioral health services, except as noted below, are also covered. The following services are excluded from behavioral health reinsurance coverage under this program as they are included as a part of regular reinsurance:

   a) Individual and group behavioral health counseling

   b) Acute care hospitalization, including psychiatric hospitalization

   c) Durable medical equipment and medical supplies

   d) Pharmaceuticals

   e) Physician services, and

   f) Therapies, including physical therapy, occupational therapy, speech therapy and respiratory therapy.

Refer to the Encounter Reporting User Manual and the AHCCCS Reinsurance Claims Processing Manual for information regarding reporting and payment issues. These manuals are available on the AHCCCS Web site at www.azahcccs.gov.

X. OUT-OF-STATE PLACEMENT STANDARD

Out-of-state services are covered as provided for under 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States (as defined in Chapter 300) are not covered.

This section of the manual is intended to address the standards related to the long term placement of members in out-of-state settings. It does not apply to situations in which the member is temporarily absent from the State.

Out-of-state placements may be approved in licensed/certified residential-type settings only (for example, nursing facilities, residential treatment centers, group homes). Personal residences outside of the State of Arizona are not approved placements. Out-of-state facility providers must be registered with AHCCCS.

Written authorization from AHCCCS is required prior to the placement of an ALTCS member in an out-of-state placement.

In addition to all other ALTCS case management standards, the following standards also apply when the Contractor seeks an out-of-state placement:

A. A request for out-of-state placement must be submitted to AHCCCS when it is determined that an ALTCS member's need for services cannot be met by existing providers within the State of Arizona.

B. Tribal Contractors requesting out-of-state placement approval for members being placed in one of the nursing facilities in Utah or New Mexico must submit a written request to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit using the form found in Exhibit 1620-7.

C. Program Contractors requesting out-of-state placement approval must submit a written request to the AHCCCS/Division of Health Care Management (DHCM)/ALTCS Unit. The request must include at least the following information:

    1. Member name and AHCCCS ID#

    2. Name/location of facility where the Contractor intends to place the member

    3. Description of the member's medical/behavioral condition that necessitates this placement

    4. Description of facility's program(s) that makes this placement appropriate for the member

    5. Information about other in-state placement options ruled out for the member, and

    6. Plan for member's return to an Arizona placement

D. When justified, AHCCCS approvals are generally given for six month intervals. The case manager must submit appropriate documentation to request a renewal if the out-of-state placement is expected to continue beyond the initial approval time period. Requests for renewals must be submitted prior to the expiration of the previous approval.

XI. SKILLED NURSING NEED STANDARD

The case manager is responsible for ensuring that a member who has skilled nursing needs is provided with the monitoring and care necessary to meet his/her individual needs.

Non-Institutional Settings

A. The member's initial needs assessment must be conducted by an AHCCCS registered home health agency if the member is at risk of compromising his/her skin integrity (for example, the member is bed bound, quadriplegic) or if the member has a history of medical instability (for example, frequent seizures, unstable diabetes, COPD). If a registered home health provider is not available, an independent registered nurse may conduct the assessment for skilled nursing needs. Thereafter, the member will be monitored for skilled nursing needs, by the home health agency or independent registered nurse, within established timeframes and as otherwise necessary. DES/DDD may utilize its district nurses in performing these assessments and making recommendations to the PCP for continued monitoring.

B. A member who has skilled nursing needs for conditions (for example, pressure ulcers, surgical wounds, tube feedings, pain management and/or tracheotomy) must be referred to a home health agency for the initial assessment and the ongoing provision of skilled nursing care as well as monitoring determined necessary by the assessment. An independent registered nurse may provide these services if an AHCCCS registered home health agency is not available.

C. The case file must reflect quarterly consultations with the provider of the skilled nursing care and documentation of the member's condition and progress until the member no longer requires skilled nursing care.

D. If the member or member representative refuses skilled nursing care, the case manager must inform the member or representative of the possible risks of refusing such care. The case manager must, at a minimum, document in the case management file the reason given for refusing the recommended care and that the member or representative has been informed of the risks. The member's PCP must also be informed of the refusal.

Institutional Settings

A. The facility is responsible for providing appropriate care to meet the needs of each member who is at risk of compromising his/her skin integrity (for example, the member being bed bound, quadriplegic, or having a history of medical instability such as frequent seizures, unstable diabetes, COPD) and members who require skilled nursing for other conditions such as pressure ulcers, surgical wounds, and/or pain management.

B. Every six months, the case manager must consult with the appropriate facility staff and review treatment record documentation related to the member's condition and progress. The member's progress related to the specific skilled nursing need(s) must then be documented in the case management file.

C. If the member or member representative refuses skilled nursing care, the case manager must coordinate with facility staff to ensure the member or representative has been informed of, and understands, the possible risks of refusing the care. The case manager must, at a minimum, document in the case management file that the member or representative has been informed of such risks and the member's reason for refusing care. The member's PCP must also be informed of the refusal of care.

XII. CASE FILE DOCUMENTATION STANDARD

A. Case file documentation must be complete and comprehensive. It may be written by hand or typewritten. Each case file page should indicate the member's name and identification number. Each entry made by the case manager must be signed and dated. If electronic records are utilized, the Contractor must ensure the integrity of the documentation. AHCCCS may request that documentation kept in an electronic system be printed out for purposes of a case file review.

B. Contractors must adhere to the confidentiality standards under the Health Insurance Portability and Accountability Act (HIPAA).

C. Case files must be kept secured.

D. Program Contractors are expected to maintain a uniform tracking system for documenting the begin and end dates of those services listed in the Placement/Service Planning Standard section of this chapter (excluding transportation), as applicable, in each member's chart. This documentation is inclusive of renewal of services and the number of units authorized for services.

E. Tribal Contractors must show authorization of services on the CA165/Service Plan.

F. Case files must include, at a minimum:

1. Member demographic information, including residence address and telephone number, and the emergency contact person and his/her telephone number

2. Identification of the member's PCP

3. Uniform Assessment Tool (UAT), completed at least annually

4. Information from 90/180 day on-site assessments that addresses at least the following:

a. Member's current medical/functional/behavioral health status, including strengths and needs

b. The appropriateness of member's current placement/services in meeting his/her needs, including the discharge potential of an institutionalized member

c. The cost effectiveness of ALTCS services being provided

d. Identification of family/informal support system or community resources available to assist the member

e. Identification of service issues and/or unmet needs, an action plan to address them and documentation of timely follow-up and resolution.